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Sourcebook of Treatment Programs for Sexual Offenders

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Springer Science+Business Media, LLC

Library of Congress Cataloging-in-Publication Data

Sourcebook of treatment programs for sexual offenders / edited by
William Lamont Marshall ... [et al.].
p. cm. -- (Applied clinical psychology)
Includes bibliographical references and index.
ISBN 978-1-4899-1918-2
1. Sex offenders--Mental health services. 2. Sex offenders-
-Rehabilitation. I. Marshall, William L. II. Series.
RC560.S47S68 1998
362.2'7--dc21 98-21057
CIP

ISBN 978-1-4899-1918-2 ISBN 978-1-4899-1916-8 (eBook)
DOI 10.1007/978-1-4899-1916-8

Originally published by Plenum Press, New York in 1998
Softcover reprint of the hardcover 1st edition 1998

10 9 8 7 6 5 4 3 2 1

". . . the doctrine that you can't change human nature has a larger purpose: defense of the existing social arrangements."

—Barrows Dunham
Man against Myth, 1947

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Preface

A tradition has been defined, somewhat facetiously, as something we did last year, enjoyed, and therefore have decided to do again. This volume fits that tradition in that, just as the *Handbook of Sexual Assault* (Marshall, Laws, & Barbaree, 1990) was conceived over a meal at the annual meeting of the International Academy of Sex Research held in Amsterdam in 1986, this present volume arose from discussions during the 1994 Association for the Treatment of Sexual Abusers conference held in San Francisco. One of the benefits of attending such meetings is the chance to crystallize thoughts. It seemed clear to us in San Francisco that what was missing from the literature on sexual offenders was guidance on how to implement treatment in the quite different, and often difficult, settings in which it is offered and how to provide treatment to the increasingly diverse subgroups of sexual offenders that are seen in all settings. We decided to do our best to fill that gap.

Looking back over the history of our collective attempts to treat men who behave in sexually aggressive ways, we can only be impressed by the creative energy that has been expended. The early behavioral approaches, born from a sense of optimism created by behavior therapy's success in assisting chronically psychiatrically disabled people lead happier more fulfilled lives, have been augmented by the broader social learning approaches. These in turn have been extended by the development of the now most commonly used theory of treatment: relapse prevention. While this approach to structuring interventions is not without its problems, it has become the touchstone against which any competing intervention is evaluated. Most critically it has articulated optimism, at least for therapists, and has very usefully served to place our focus on the dynamic process of offending.

One of the major issues for the area has centered around whether treatment is the most rational response to sexual abuse. Some members of the professional community (e.g., Quinsey, Rice, Harris, & Lalumière, 1993) have espoused sceptical views of the value of treatment. They have quite rightly pointed out that the extant treatment outcome literature has methodological weaknesses that preclude definitive conclusions. We (Marshall, 1993; Marshall & Pithers, 1994; Marshall, Ward, Jones, Johnston, & Barbaree, 1991), on the other hand, have taken a more optimistic view and have read into this same literature encouraging signs of the potential of treatment. In addition, we are further encouraged by the growing body of research indicating that similar cognitive–behavioral programs produce positive benefits among nonsexual offenders (Andrews et al., 1990). In any event, whatever position is assumed with regard to treatment efficacy, it is clear that many clinicians worldwide are engaging in interventions with sexual offenders aimed at reducing their propensity to reoffend.

Given the rather low base rates of reoffending among sexual offenders and the associated difficulty in demonstrating treatment effects, it may be some time before any program has generated enough treatment graduates at risk for a sufficient period of time to

demonstrate any effects (Barbaree, 1997). In the meantime, the pressing questions for practitioners have more to do with how we go about treating sexual offenders and what sort of adjustments we have to make in our programs to address the unique features of both our clients and the settings in which we work. What are the particular problems that therapists face in treating sexual offenders in prisons, in psychiatric facilities, and in community settings? In what ways do we need to modify our programs and educate ourselves in order to effectively treat differing populations of sexual offenders? Are juveniles, women, professionals, aboriginals, and disabled offenders all responsive to the same treatment approach, or must we make changes to our programs to accommodate their special needs?

Our goal in this volume is to offer some answers to these questions by selecting authors who have experience and expertise in working with these diverse populations in different settings and in different countries. In this way, we hope that readers will not have to individually reinvent the wheel, but rather will be given guidance not only about the specific features that need to be addressed in treatment but also about the likely problems they may face and how they might deal with these difficulties. Since resources are typically in short supply, there is seldom the luxury of having several months available to develop the structure and content of a program prior to seeing the first client. We therefore hope that the present volume will provide guidance that will allow practitioners to more rapidly develop a sound approach to their particular population or circumstance.

The broad settings we have chosen are meant to be illustrative of the creativity that currently abounds. We have included programs operating in prison settings, psychiatric hospitals, and in the community, as well as programs dealing with special populations, including juveniles, women, clergy, professionals, variously disabled offenders, and aboriginal offenders. We also have secured representative authors from different countries who describe their programs in order to illustrate the unique circumstances and opportunities provided by each country. Despite this diversity, what is perhaps most surprising is the relative uniformity of the basic aspects of each program described in this volume. The unique features of each program are built into a core, which is essentially the cognitive–behavioral program that has been evolving in North America over the past 20–30 years, with relapse prevention as the latter-day integrative perspective.

With so many programs operating worldwide and with most of them based on the same approach, we should be in a far better position, some 10 years hence, to make a clearer estimate of the value of treating sexual offenders. However, simply counting the number of treated offenders who recidivate will never tell us the real value of treatment. It is the reduction in the number of innocent victims who are so disastrously damaged by sexual abuse that is the real key to evaluating treatment programs for sexual offenders, as well as the financial savings to society. It is already clear that for treatment to be valuable in these terms, it does not have to be dramatically successful. Preventing only 1 or 2% of sexual abusers from reoffending has a real impact on the integrity of the lives of possible victims and saves society (i.e., the taxpayers) a significant amount of money (Marshall, 1992; Prentky & Burgess, 1991). Most treatment providers apparently have a more optimistic view than this minimum would suggest of the effectiveness of their treatment.

We hope that the present volume will encourage clinicians to see that neither the physical circumstances in which treatment is delivered nor the specifics of any given offender group are insurmountable obstacles to implementing effective programs for sexual offenders. We also hope that this volume will encourage greater international cooperation and communication between treatment providers. We think that each of our authors has

done an excellent job in describing their program, its difficulties, and their solutions, and hopefully their experience will assist others in developing their own programs.

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Acknowledgments

Primarily, we would like to thank our authors for their contributions. All are active clinicians or program directors who have so many other tasks that it is remarkable they were able to give up the time to describe their programs. We heartily thank them.

Thanks also are due to Kathleen Lucadamo, our editorial help at Plenum Publishing, for her guidance and patience, and Val Angus, who provided valuable typing assistance with the edited manuscripts.

More generally, we acknowledge the support and encouragement of our family, friends, and colleagues, who made the task easier.

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